VERIFICATION OF ELIGIBILITY AND APPLICATION FOR CERTIFICATION EXAMINATION

Please disregard if currently certified by a national organization for advanced nursing practice.

To the Candidate ————————————————————————————————————
This verification form must be completed by the appropriate national certifying organization. Contact the certifying organization regarding any fees that may be required for this service. Forward this form to the applicable organization with a letter requesting its completion. THE NATIONAL ORGANIZATION MUST DIRECTLY MAIL THIS FORM TO THE ATTENTION OF THE "ARNP UNIT" AT THE KENTUCKY BOARD OF NURSING ADDRESS PROVIDED ON THE TOP OF THE FORM.
Certification Examination Candidate's Last Name: Certification Examination Candidate's First Name:
Type of Advanced Practice - Designated Nurse: Anesthetist Practitioner Midwife Clinical Specialis
National Certifying Organization:
Please release my test results to the Kentucky Board of Nursing.
Signature Date:
DO NOT WRITE BELOW THIS LINE INFORMATION BELOW THIS LINE IS TO BE COMPLETED BY THE NATIONAL CERTIFYING ORGANIZATION
To the National Certifying Organization ————————————————————————————————————
Complete this portion of the Verification of Eligibility and Application for Certification Examination form, and then MAIL THIS FORM DIRECTLY TO THE "ARNP UNIT" AT THE KENTUCKY BOARD OF NURSING ADDRESS LISTED ON THE TOP OF THE FORM. If questions, call 502-429-3329.
Examination Information
First-Time Candidate or Repeat Candidate
Scheduled to Take Exam Or Exam Taken Date of Exam:
─ Verification Statement ─
This is to verify that the candidate listed above has met eligibility requirements and has applied to take the examination for certification for advanced practice.
S E A L
Name:
Title:
Organization's Phone #: Ext:
Date: 4/2005